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No.

IN THE

Supreme Court of the United States

October Term, 1986

UNIVERSITY OF CINCINNATI,
d/b/a UNIVERSITY HOSPITAL

Petitioner

--vs.--

SECRETARY OF HEALTH & HUMAN SERVICES

Respondent

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

Whether 42 U.S.C. §1395oo mandates the Provider Reimbursement Review Board (the "Board") to exercise jurisdiction over costs covered by a Medicare provider's cost report but not claimed as reimbursable by the provider and thus not reviewed and considered by the Secretary's fiscal intermediary.

PARTIES

Petitioner is the University of Cincinnati, d/b/a University Hospital, who is the Plaintiff in the proceedings below. Respondent is the Secretary of Health & Human Services, appointed by the President of the United States and responsible for the administration of the Medicare program.

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PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Petitioner, University of Cincinnati, d/b/a University Hospital, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals, Sixth Circuit, entered in the above-entitled proceeding on January 15, 1987, Petition for Re-Hearing *en banc* denied on March 19, 1987.

OPINION BELOW

The opinion of the United States Circuit Court of Appeals for the Sixth Circuit, reported at 809 F.2d 307, appears in the Appendix at A-1. The United States Court of Appeals for the Sixth Circuit denied Petitioner's Petition for Re-Hearing *en banc* on March 19, 1987 which denial also appears in the Appendix.

JURISDICTION

The United States Court of Appeals for the Sixth Circuit entered its decision on January 15, 1987. A timely Petition for Re-Hearing *en banc* was filed and then denied by the Sixth Circuit on March 19, 1987. This Petition for Certiorari was filed within 90 days of that date pursuant to Supreme Court Rule 20.2 and .4. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

42 U.S.C. §1395oo(a) states:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such times as the Secretary may require in order to make payments under such section may obtain a hearing with respect to such payment by the Board, if--
>
> (1) Such provider--
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) The amount in controversy is $10,000 or more, and

(3) Such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. §1395oo(d) states:

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal

intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

STATEMENT OF THE CASE

The Medicare program is set forth in subchapter XVIII of the Social Security Act, 42 U.S.C. §1395, *et seq.* (1982). Part A of the program, under which this case arises, authorizes federal reimbursement for hospital care provided to the elderly and disabled. 42 U.S.C. §§1395c-1395i-2. Until recently, a health care "provider" (e.g., a hospital) submitted annual cost reports to a "fiscal intermediary" (usually a private insurance company) for review; the fiscal intermediary acted as an agent of the Secretary of Health & Human Services. The intermediary audited the cost report and issued a Notice of Program Reimbursement with an explanation of any audit adjustments or disallowed costs. If the provider was not satisfied, the statute provided an avenue of administrative appeal to the Provider Reimbursement Review Board ("Board"), 42 U.S.C. §1395oo.

Petitioner University of Cincinnati, d/b/a University Hospital (hereinafter the "Hospital"), is a full-service, teaching hospital and the largest Medicare provider in the area. As a teaching facility, it sponsors over 20 post-graduate residency programs, two of which are contained at the Family Practice Center ("FPC") and the Central Psychiatric Clinic ("CPC"). During the three-year time period beginning on July 1, 1979 and ending on June 30, 1981, University Hospital incurred substantial costs at each of these clinics on behalf of Medicare-eligible patients.

While the Hospital reported those clinical costs in its annual cost reports, it did not seek reimbursement for such costs because it had been led to believe that such costs were non-reimbursable under the Medicare program. Rather than claim the costs and have the intermediary disallow them when it performed an

audit, the Hospital inserted the costs in the cost report and then "self-disallowed" them. In other words, these clinical costs were covered by the cost reports for these three years but no reimbursement was specifically sought for them.

Subsequent to the filing of its third and final cost report for this three-year period (on or about October 30, 1981), the Hospital learned of an important judicial decision which held that Pennsylvania State University could obtain reimbursement for its costs incurred at similarly situated clinics on behalf of Medicare-eligible patients. *See, The Pennsylvania State University v. Secretary*, PRRB Dec. No. 79-D89, CCH Medicare & Medicaid Guide, paragraph 39,379, *reversed and remanded* (D.C. M.D. Pa., 1981), CCH Medicare & Medicaid Guide, paragraph 30,989, and 79-D89R, CCH Medicare & Medicaid Guide, paragraph 31,635. Accordingly, after the Secretary's fiscal intermediary completed its Medicare audit for the three cost years in question (FYEs 6-30-79, 6-30-80 and 6-30-81) and had issued its Notice of Program Reimbursement on or about September 30, 1982, the Hospital initiated an administrative appeal to the Board seeking reimbursement for a variety of costs which it had incurred on behalf of Medicare-eligible patients but for which it had not been reimbursed.

Some of these costs are the costs relating to the Family Practice and Central Psychiatric Clinics. These costs totalled $2,764,513 which, if reimbursable, would generate $530,624 in Medicare funds. However, the Board refused to exercise its jurisdiction to review the reimbursability of these costs. The Board's refusal was based on the simple fact that the Hospital had not claimed in its cost reports that these clinical costs were reimbursable and, therefore, the intermediary had never made a determination on the issue. The Board maintained that such a determination was a condition precedent to its own jurisdiction. As a result of the Board's refusal to exercise jurisdiction, the Hospital has been denied the opportunity to obtain reimbursement for actual costs incurred on behalf of Medicare-eligible patients in the amount of $530,624.

On April 13, 1984, Petitioner filed its Complaint in the United States District Court for the Southern

District of Ohio, Western Division, pursuant to 42 U.S.C. §1395oo(f) and 28 U.S.C. §1331. On April 19, 1985, the District Court granted summary judgment in favor of the Petitioner. The Secretary timely appealed this decision to the United States Court of Appeals for the Sixth Circuit which reversed on January 15, 1987 and which subsequently denied Petitioner's Petition for Re-Hearing *en banc*.

REASONS FOR GRANTING THE WRIT

I. THE WRIT SHOULD BE GRANTED BECAUSE THE DECISION BELOW CONFLICTS DIRECTLY WITH THE DECISIONS OF OTHER UNITED STATES CIRCUIT COURTS OF APPEALS.

The decision by the United States Court of Appeals for the Sixth Circuit in this case conflicts directly with the decisions of the United States Courts of Appeals for the First, Seventh and Ninth Circuits. Each of these courts held that the Board does have the power, under 42 U.S.C. §1395oo, to consider reimbursement claims not expressly made to a fiscal intermediary in a cost report. *See, St. Luke's Hospital v. Secretary of Health & Human Services*, 810 F.2d 325 (1st Cir., 1987); *St. Mary of Nazareth Hospital Center v. Dept. of Health & Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983); and *Adams House Health Care, et al. v. Heckler*, Nos. 85-1512, 86-1872 (9th Cir., May 18, 1987). Admittedly, other federal courts have held that the Board's power is narrowly limited to considering only those costs which the intermediary has previously considered, reviewed and acted upon. *See, Athens Community Hospital, Inc. v. Schweiker*, 743 F.2d 1 (D.C. Cir., 1984) ("Athens II"); *Community Hospital of Roanoke Valley v. Health & Human Services*, 770 F.2d 1257 (4th Cir., 1985); *Baptist Hospital East v. Secretary of Health & Human Services*, 802 F.2d 860 (6th Cir., 1986); and *North Broward Hospital District v. Bowen*, 808 F.2d 1405 (11th Cir., 1987).

The First Circuit, Seventh Circuit and Ninth Circuit have all squarely held that the Board has

jurisdiction over self-disallowed costs and that the Board's jurisdiction is not contingent upon the fiscal intermediary first reviewing, considering and acting upon a particular cost. It is worth noting that while particular costs may be covered by the cost report, if it is self-disallowed, the intermediary is simply not going to review it. The intermediary only reviews the costs for which the hospital seeks reimbursement. By definition, a self-disallowed cost is one for which the hospital seeks no reimbursement.

It should also be pointed out that both the Seventh Circuit and Ninth Circuit held that the Board must exercise its jurisdiction over self-disallowed costs so long as the provider files a timely and proper appeal. The First Circuit took a different approach. It held that the Board had discretion to hear appeals or not, relying on language in 42 U.S.C. §1395oo(d) providing that the Board "shall have the power" to do certain things. *See, St. Luke's*, 810 F.2d at 327-28. The Ninth Circuit specifically rejected the First Circuit's holding that the discretionary language ("shall have the power") describes the Board's power to accept or reject appeals. It held that this language simply describes the Board's options once an appeal is filed.

The Sixth Circuit, in both *Baptist East* and in the decision below, adopted the approach of the D.C. Circuit in *Athens II*, as did the Eleventh Circuit in *North Broward* and the Fourth Circuit, with some minor differences, in *Roanoke Valley*. In *Athens II*, the D.C. Circuit held that since the statutory scheme was both puzzling and ambiguous, the agency's reasonable interpretation is entitled to deference even if it appears to conflict with one part of the scheme. Interestingly, the Seventh Circuit specifically found that the language in 42 U.S.C. §1395oo(d) was both plain and decisive on the issue inasmuch as it states very clearly that the Board may review even matters "not considered by the intermediary."

With four circuits, including the Sixth, holding that the Board has no jurisdiction over costs not previously reviewed and considered by the Secretary's intermediary, and with three other circuits specifically rejecting this rationale and holding that the Board does have jurisdiction over such costs, there is indisputably

a loud and clear split among the circuits which can only be resolved by this Court.

II. THE WRIT SHOULD BE GRANTED BECAUSE THE QUESTION PRESENTED IS IMPORTANT NOT ONLY TO THE PETITIONER BUT TO ALL HEALTH CARE PROVIDERS PARTICIPATING IN THE FEDERAL MEDICARE PROGRAM.

It is important for this Court to resolve the split in the circuits regarding the jurisdiction of the Board over costs which have not been previously considered by the Secretary's fiscal intermediary not only because there should be a uniform understanding and application of the statute but also because an erroneous decision, like the Sixth Circuit's, results in large, unreimbursed costs which frustrates the purpose of the Medicare Act itself and which, unfortunately, ultimately hampers the delivery of vitally needed medical services to the aged and disabled of this country.

The very real practical effect of the Board's understanding of its jurisdiction, as affirmed by four circuits including the Sixth, is that hospitals do not get reimbursed for legitimate and actual costs which they incurred on behalf of Medicare-eligible patients. Obviously, this is not fair to the hospitals themselves and it is completely contrary to the intent and purpose of the Medicare Act itself. Over $500,000 is potentially due University Hospital in Medicare reimbursement funds for services rendered during one three-year period at two of its clinics. This amount could easily be multiplied many times over by an unknown number of hospitals throughout this country. The stakes are high not only to the providers but to their patients as well.

Of course, it is possible that, when and if the Board does exercise jurisdiction over the Hospital's self-disallowed clinical costs, the Board will decide that such costs are non-reimbursable. However, in that case, the Hospital will then have the right to seek judicial review of that substantive decision pursuant to 42

U.S.C. §1395oo(f). Without Board jurisdiction over particular costs, a provider is barred from seeking judicial review of a particular cost. *Hadley Memorial Hospital, Inc. v. Schweiker*, 689 F.2d 905 (10th Cir., 1982). The Board's refusal to accept jurisdiction over particular claims prevents providers from obtaining the judicial review specifically provided by statute.

This is an important issue which the Court should not ignore.

III. THE WRIT SHOULD BE GRANTED BECAUSE THE DECISION BELOW IS ERRONEOUS.

In following the *Athens II* rationale, the Sixth Circuit perpetuated the errors memorialized in that case. The Medicare statute clearly affords hospitals the right to administrative and judicial review if certain conditions are met. The statute states that "any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . ." if certain conditions are met, 42 U.S.C. §1395oo(a). There is no question that the Hospital timely filed its cost report with the fiscal intermediary, as required by statute, regulation and administrative instructions. Thus, it is entitled to a hearing "with respect to such cost report," whether or not they actually claimed reimbursement for a specific cost. (The Hospital meets the other conditions set forth in §1395oo(a): the amount in controversy exceeds $10,000; the Hospital is obviously dissatisfied with the amount of total program reimbursement; and their hearing requests were filed within 180 days of the intermediary's determination.) Contrary to the Secretary's reading of §1395oo(a), *nowhere* in the statute is there a requirement that a provider must provide separate "notice" of a dispute to the intermediary at the time it files its cost report in order to meet the prerequisites to obtain a hearing "with respect to such cost report" before the Board.

The Secretary's position that the Board cannot hear a provider's appeal unless self-disallowed costs are accompanied by some notice of the dispute to the

intermediary is flatly contrary to the plain language of the statute in another respect. The Medicare statute confirms the Board's broad jurisdiction over hospitals meeting the threshold requirements for a hearing:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report *and* to make any other revisions *on matters covered by such cost report* (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary* in making such final determination. 42 U.S.C. §1395oo(d) (Emphasis added)

Thus, so long as the costs at issue are "covered by such cost report," the Board has the power to make revisions concerning such costs, even if the intermediary did not consider them.

The phrase "matters covered by such cost report" raises the question of what constitutes the cost report. The cost report is not a single page or schedule; it comprises numerous schedules, worksheets and supplemental worksheets. The costs associated with the two clinics here were included in the Hospital's cost reports and were conceded to be so included by the Secretary in the proceedings below. Whether or not the intermediary revised ("adjusted") those particular clinical cost items in the process of making a final determination is irrelevant under the statute. The costs are within the Board's jurisdiction so long as they were "covered by such cost report." Clearly, the costs at issue here are so covered.

The Secretary has argued that, in addition to the tests set out in the statute, the Hospital must include some type of "overt notice" to the intermediary with the cost report. As demonstrated above, there is no statutory authority for this restriction of hospital appeal rights. Moreover, the Secretary's position is both unreasonable and inequitable, and should be rejected. Adoption of the narrow and strained interpretation of the statutory grant of jurisdiction for Medicare

reimbursement appeals urged by the Secretary would unreasonably limit hospital appeal rights. Such a result runs contrary to the presumption favoring judicial review, recently affirmed by the Supreme Court in another Medicare case.

> We begin with the strong presumption that Congress intends judicial review of administrative action. From the beginning 'our cases [have] established that judicial review of a final agency action by an aggrieved person will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress.' *Abbott Laboratories v. Gardner*, 387 U.S. 136, 141 (1966).

Bowen v. Michigan Academy of Family Physicians, 106 S.Ct. 2133 (1986). Given the absence of statutory language requiring overt notice of a dispute, a court would have to apply a presumption *against* reviewability in order to support the Secretary. Such a position is clearly contrary to the teachings of *Michigan Academy*.

Moreover, when these cost reports were filed, none of the numerous schedules which constitute a cost report provided an opportunity to register a dispute with the intermediary. There was no notice in the cost report, instructions or regulation that appeal rights would be lost if the provider "self-disallowed" a cost. Moreover, the cost report itself warns that misrepresentation of data on the cost report may be punishable by fine or imprisonment. It is certainly understandable that some hospital administrators would take a self-disallowance if in doubt as to the allowability of certain costs.

The Secretary's position, as endorsed by *Athens II* and its progeny (including the decision below), has recently been carefully reviewed and thoroughly rejected by both the First and Ninth Circuits. Petitioner maintains that these cases are better reasoned and that with respect to the mandatory nature of the Board's jurisdiction, the Ninth Circuit is the better decision of the two.

In *Adams House*, the Ninth Circuit, like the Seventh Circuit in *St. Luke's*, felt that the plain language of the statute settled the question of whether the Board could hear matters not previously raised before a fiscal intermediary. The simple rationale was that §1395oo(d) authorized the Board to review even those matters ". . . not considered by the intermediary." Since the D.C. Circuit found a way to ignore this plain language, it was necessary for the Ninth Circuit to carefully and thoroughly analyze the discussion in *Athens II*. In this case, the D.C. Circuit held in effect, that to give full force and effect to the plain language of the statute would be contrary to the statutory scheme and ". . . would have adverse practical consequences, and conflicts with the reopening regulations [42 C.F.R. §405.1885, *et seq.* (1986)] as well as the agency's own interpretation of the statute." *Athens II*, 743 F.2d at 6. The Ninth Circuit rejected each one of the arguments in *Athens II*.

First, the *Athens II* court held that a literal reading of subsection (d), by which the Board has the power to review matters not raised before the intermediary, "ignores and would make meaningless another part of subsection (d), which limits the Board's power of review to 'matters covered by [a] cost report.'" *Athens II*, 743 F.2d at 6. The Ninth Circuit held that there was no contradiction and that the phrase "covered by a cost report" should be read broadly. It held that a cost is "covered by a cost report" if it was incurred within the period which is the subject of the report and is reflected in that report, even if not expressly claimed.

The next argument of the D.C. Circuit was that a literal reading of §1395oo(d), by which the Board has the power to consider matters not claimed before an intermediary, would conflict with subsection (a) which requires that a provider must be "dissatisfied with the final determination of its intermediary" before being entitled to a Board review.

> It simply is not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure

> because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for even though it did not request them.

Athens II, 743 F.2d at 6.

Section (a) only requires that a provider be dissatisfied with the total amount of reimbursement offered by the intermediary, not with the intermediary's reasoning process as to any specific costs. The Ninth Circuit pointed out that a provider's failure to claim particular costs at the intermediary level certainly reflects no fault or neglect on them, as *Athens II* seems to suggest; rather, it reflects the fact that a claim would have been pointless. In the present instance, the provider had been led to believe that the clinical costs were not reimbursable well in advance of preparing its cost reports. Accordingly, as soon as the Hospital was before the Board, it made its dissatisfaction regarding specific reimbursement known. The language of subsection (a) requires no more and it does not conflict with subsection (d).

The Ninth Circuit also rejected the "adverse consequences" which the D.C. Circuit feared would result if the Board could review cost items not claimed before an intermediary. The D.C. Circuit feared the padding of cost reports with every conceivable cost and subsequent frivolous appeals. The Ninth Circuit rejected this fear holding that both types of abuses could be contained by the anti-fraud provisions of 42 U.S.C. §1395nn.

The D.C. Circuit also feared that a rejection of the Secretary's position would ". . . deprive [the Board] of the intermediary's analysis and conclusions and make the [Board] the tribunal of original jurisdiction, eliminating a tier of review." *Athens II* at 6-7 (quoting *Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989, 997 (D.C. Cir., 1982) ("Athens I")). However, both *Adams House* and *St. Luke's* rejected this argument by pointing to the fact that Congress deliberately set up the Board's review procedures as a hybrid, exhibiting some features of initial fact finding (witnesses, cross-examination, new evidence) and some features of review. *St. Luke's*, 810 F.2d at 328.

Finally, the third apprehended consequence was that a rejection of the Secretary's interpretation would render virtually meaningless the time limits for the filing of cost reports established by 42 C.F.R. §405.453(f)(2) (1983). This is a particularly weak argument of the D.C. Circuit since, in order to perfect an appeal, a provider must file its cost report within three months of the end of the reporting period and, if no report is filed, the provider would be without relief. *See, Athens I*, 686 F.2d at 994 and n. 7.

The next argument of the D.C. Circuit does not neatly apply to the facts of Petitioner but it is an argument, nevertheless, which should be rejected. The D.C. Circuit argued that to reject the Secretary's understanding of its jurisdiction would result in a conflict with the Secretary's so-called "reopening" regulations. These provisions, 42 C.F.R §405.1885, *et seq.*, allow providers limited rights to amend already filed cost reports. When a provider seeks permission of its intermediary, pursuant to regulation, to reopen its cost report and such permission is denied, and if the provider then attempts to take the proposed amended-but-rejected costs and place them in the controversy of an already pending administrative appeal before the Board, then, if the Board is mandated to hear such costs, the reopening regulations of the Secretary have been made meaningless. The Court felt that the finality provision of 42 C.F.R. §405.1885(d) would have been voided. However, this complicated argument is without merit. As the Ninth Circuit pointed out, an appeal to the Board does not force an intermediary to reopen its deliberations. There is finality at the intermediary level. The D.C. Circuit's idea that this finality should extend to the Board stems from the notion, which should be rejected, that the Board exercises purely a power of review with no element of initial jurisdiction.

Lastly, the D.C. Circuit argued that deference ought to be given to the Secretary in his interpretation of the statutory scheme. However, the Ninth Circuit specifically rejected this argument noting that the Board has no special expertise at interpreting provisions governing jurisdiction. As this Court has made very clear:

> . . . deference is not to be a device that emasculates the significance of judicial review. Judicial deference to an agency's interpretation of a statute "only sets 'the framework for judicial analysis; it does not displace it.'" *United States v. Vogel Fertilizer Co.*, 455 U.S. 16, 24 (1982), quoting *United States v. Cartwright*, 411 U.S. 546, 550 (1973). A reviewing court "must reject administrative constructions of [a] statute, whether reached by adjudication or by rule-making, that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Federal Election Commission v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32 (1981).

Securities Industry Assn., et al. v. Board of Governors of the Federal Reserve System, et al., 104 S.Ct. 2979, 2983 (1984).

In reaching its decision, the First Circuit also relied on the legislative history of the statute to conclude that the statute means what it says. It relied on the House Committee Report where it says that the Board ". . . may affirm, modify, or reverse the fiscal intermediary's determination, including revisions which are adverse to the provider and revisions involving matters not considered by the intermediary." H. Rep. No. 231, 92d Cong. 2d Sess., *reprinted in 1972 U.S. Code Cong. & Ad. News*, 4989, 5309. This same report also states that the Board's decisions:

> . . . would have to be based on the record made at [the] hearing [before the Board], which may include any evidence submitted by the Department . . . [as well as] the evidence of record considered by the intermediary . . . [The] Board may find in whole or in part for the provider or the Government (*including a finding based upon the*

> *evidence before it that the provider owes sums in addition to the amount raised in appeal).*

Id., 1972 U.S. Code Cong. & Ad. News at 5094-95 (emphasis added). The First Circuit relied on the above legislative history to conclude that:

> The underscored language does not make much sense if the Board may only consider issues already explicitly disputed between the provider and the intermediary. It makes considerable sense, however, once one remembers that the Board's procedure is a kind of "hybrid," exhibiting some features of initial fact finding (witnesses, cross-examination, new evidence) and some features of review. Such a process may develop new information calling for revisions to the intermediary's final cost figure in an unanticipated way; where the provider might have thought the intermediary's figure too low, the Board, for totally different reasons, might think it too high. Given its hybrid procedure, Congress might reasonably have wished the Board to understand that it has the *power* to make any modifications (in either direction) that new information before it seems to call for.

St. Luke's, 810 F.2d at 328. This legislative history and case law clearly demonstrates that the fiscal intermediary is nothing but an auditor applying the Secretary's rules, issuing an audit report. The intermediary has no deliberative authority. Accordingly, any characterization that the Board functions merely as the "second tier appellate body" is meaningless.

Accordingly, in following *Athens II* and in becoming part of its progeny, the Sixth Circuit rendered an erroneous decision. The better case law, as

supported by legislative history and well-considered arguments, demonstrates that, pursuant to 42 U.S.C. §1395oo(a) and (d), the Board has jurisdiction, assuming compliance with other requirements, over all costs covered by the cost report even though such costs may not have been previously claimed by the provider as reimbursable and thus never considered, reviewed or in any way adjusted by the Secretary's fiscal intermediary.

CONCLUSION

Petitioner respectfully requests that this Court issue a writ of certiorari to review the erroneous judgment and opinion of the Sixth Circuit and to resolve the important and significant conflict among the circuits in their interpretation of the Board's authority as delineated in 42 U.S.C. §1395oo.

Respectfully submitted,

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Appendix

RECOMMENDED FOR FULL TEXT PUBLICATION
See. Sixth Circuit Rule 24

No. 85-3651

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

UNIVERSITY OF CINCINNATI, d/b/a UNIVERSITY HOSPITAL,
Plaintiff-Appellee,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

ON APPEAL from the United States District Court for the Southern District of Ohio.

Decided and Filed January 15, 1987

Before: MERRITT and JONES, Circuit Judges; and THOMAS,* Senior District Judge.

THOMAS, Senior District Judge, delivered the opinion of this court, MERRITT (p. 27) and JONES, (p. 28) Circuit Judges, delivered separate concurring opinions.

THOMAS, Senior District Judge. The Board of Trustees of the University of Cincinnati operates University Hospital

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*The Honorable William K. Thomas, Senior District Judge of the United States District Court for the Northern District of Ohio, sitting by designation.

(Hospital). Hospital is a provider of services under the Medicare Act, 42 U.S.C. §§ 1395 *et seq.* The controversy between the Hospital and the Secretary involves the Provider Reimbursement Review Board's (Board or PRRB) denial of jurisdiction to hear an appeal of the Hospital relating to three annual cost reports filed by the Hospital with its fiscal intermediary, Blue Cross Association-Blue Cross of Southwest Ohio.

Pursuant to 42 U.S.C. § 1395oo(f), Hospital brought a civil action to obtain judicial review of the Board's denial of jurisdiction. The United States District Court for the Southern District of Ohio granted summary judgment for the University of Cincinnati, plaintiff-appellee. The district court declared that "the Provider Reimbursement Review Board has jurisdictional authority for the 1979, 1980 and 1981 cost years concerning the self-disallowed costs of the interns' and the residents' education and related overhead in connection with the Family Practice Clinic and Central Psychiatric Clinic issues." The Secretary appeals the district court's final judgment for the plaintiff.

On or about October 30, 1979, October 30, 1980, and October 30, 1981 the Hospital, as a provider of hospital services, filed its cost reports as required by the Medicare Act and regulations thereunder, "reporting that it had incurred certain expenses reimbursable under the Medicare Act" during the fiscal years ending mid-1979, mid-1980, and mid-1981. The Hospital reported in each of the cost reports the expenses, described by the district court, for which no Medicare reimbursement was sought, because the Hospital "mistakenly believed them to be non-reimbursable."[1]

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[1]Asked questions at oral argument about the Hospital's cost reports in the respects claimed, counsel for the Secretary responded:

> We have conceded as to their statements that they somehow claimed this cost, they have never come forward and shown us how they claimed it.

The Secretary's fiscal intermediary thereafter engaged in audits and carried on negotiations with the Hospital. On September 30, 1982 the Intermediary issued a Notice of Program Reimbursement (NPR) for each of the cost years in question.

The Hospital, on March 25, 1983, filed a request for hearing before the Provider Reimbursement Review Board for the fiscal years here in question. 42 U.S.C. § 1395oo(a), hereafter discussed, makes provision for establishment of the Provider Reimbursement Review Board and authorizes a provider of services "which has filed a required cost report within the time specified in regulations" to obtain a hearing "with respect to such cost report" by the Board. As the text set forth in the margin discloses,[2] section 1395oo(a) provides for

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. . .

> I'm going on the Hospital's assertion. We're not denying that hospitals list all of their costs, and we certainly do not dispute his assertion that it somehow—he has listed those on the cost report and that he subtracted them, making what he terms a self-disallowance.

Though the record is devoid of documentation the parties thus agree that in its cost reports the Hospital made no claim for reimbursement of the described expenses. However, it is agreed that the Hospital listed, but "self-disallowed," these costs. The Hospital says this was because it "mistakenly believed them to be non-reimbursable."

[2]In pertinent part, 42 U.S.C. § 1395oo (a) provides:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by the Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g) (2) of this section) any hospital which receives payments in amounts computed under subsection (b) of (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

appeals to the Board only by providers. The section does not grant a fiscal intermediary the right to appeal to the Board. Nor would it make any sense to allow such an appeal. After all, it is the final determination of the intermediary which has passed on the provider's cost report that is the subject of an appeal to the Board. The Board may only consider such a determination when a provider has properly brought an appeal from such determination.

> (1) such provider—
>
> (A)(1) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report
>
> . . .
>
> (2) the amount in controversey is $10,000 or more, and
>
> (3) such provider files a request for hearing within 180 days after notice of the intermediary's final determination under paragraph (1) (A) (i) . . .

Also pertinent is section 1395oo(d), discussed *infra* part I.C., which provides:

> **Decisions of Board**
>
> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

I.

A.

Before analyzing the question of the Board's jurisdiction over providers' appeals, the court needs to note the standard of review applied by the trial court in its consideration of the case below. That same standard of review must likewise control this court's analysis of the jurisdictional question.

42 U.S.C. § 1395oo(f) specifies that a civil action for judicial review of a final decision of the Board "shall be tried pursuant to the applicable provisions under Chapter 7 of title 5 [the Administrative Procedure Act], notwithstanding any other provisions in section 405 of this title." Under the Administrative Procedure Act's standard of review, the decision of the Secretary or Board may be set aside only if it is " 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.' 5 U.S.C. § 706(2)(A) (1976)." *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130, 133-34 (D.C. Cir. 1982); *Home Health Services v. Schweiker*, 683 F.2d 353, 356 (11th Cir. 1982).

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc. 467 U.S. 837, 842-843 (1984), considering the principles a court must follow in reviewing "an agency's construction of the statute which it administers," declares that if "the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress." However, if the court determines that the "statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute."

Further, in *Securities Industry Association v. Board of Governors*, 468 U.S. 137, 142-43 (1984), the Court has made clear that "deference is not to be a device that emasculates the significance of judicial review." Rather, judicial deference to

an agency's interpretation of a statute "only sets 'the framework for judicial analysis; it does not displace it.' " *Id.* at 143 (quoting *United States v. Vogel Fertilizer Co.*, 455 U.S. 16, 24 (1982), quoting *United States v. Cartwright*, 411 U.S. 546, 550 (1973)). A reviewing court "must reject administrative constructions of [a] statute, whether reached by adjudication or by rulemaking, that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Securities Industry Association*, 468 U.S. at 143 (quoting *Federal Election Commission v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32 (1981)).

B.

Mindful of these principles of judicial review, we must decide whether the Provider Reimbursement Review Board's jurisdictional interpretation of section 1395oo is "based on a permissible construction of the statute," or, on the other hand, is "inconsistent with the statutory mandate" or "frustrate[s] the policy that Congress sought to implement."

In its decision, the Provider Reimbursement Review Board found as follows:

> [T]here is no jurisdictional authority for the 1979, 1980 and 1981 cost years concerning the self-disallowed costs of the interns' and residents' education and related overhead in connection with the Family Practice Clinic and Central Psychiatric Clinic issues because the Provider failed to set forth any claim for the disputed cost in any of the filed cost reports or make any overt disclosure of a disagreement for this issue.

In a supplemental explanation for denial of jurisdiction the Board, in part, stated:

> The jurisdictional requirements to secure a Board

> hearing are set forth in 42 U.S.C. section 1395oo(a) and (b).[3]

Although the Board refers to "jurisdictional requirements," section 1395oo(a), set forth *supra* note 2, does not expressly use the word "jurisdiction." Omission of the word jurisdiction permits a search for intended jurisdictional requirements in the legislative history of section 1395oo.

The original House Bill, with few Senate amendments, became law on October 30, 1972. The House Bill, as approved by the Senate, provided for the establishment of a Provider Reimbursement Review Board. The report of the House Ways and Means Committee thus described the new procedure:

> Any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary with respect to the period covered by such a report to the Board where the amount in controversy is $10,000 or more.

H.R. Rep. No 231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 4989, 5094. The House Report further stated its belief that "it is desirable to prescribe in law a specific procedure for *settling disputed final determinations* applying to the amount of program reimbursement" (emphasis added). *Id.* The Conference Report indicates that "the Senate amendment modified the House Bill by introducing two additional situations which could serve as "a basis for provider appeals" from final decisions of the fiscal intermediary. H.R. Conf. Rep. No 1605, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 5370, 5388. In speaking of "a basis for provider appeals," the Conference Report[4] makes clear that the new

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[3]Section 1395oo(b), relating to group appeals, is not here applicable.

[4]The Conference Report noted that under present law "[t]here is no specific legislative provision for an appeal by the provider of the inter-

procedure was to be an appellate process and that to obtain an appeal the provider must satisfy the statutory basis for the appeal.

The statute itself, in section 1395oo(a), declares that the provider must file "a required cost report," and submit "such reports . . . as the Secretary may require." Thus, the statute makes the submission of a "required cost report" a condition precedent for a provider to obtain a Board hearing.

In writing this mandate into the Medicare Act, Congress was aware that the Secretary had adopted various regulations governing a provider's submission of cost reports. Nothing in the statute suggests that Congress intended to disturb such regulations. Rather, Congress mortised together the new statutory language and the existing regulations.[5]

42 C.F.R. § 405.406(b),[6] adopted by the Secretary in 1966,[7] required providers of services to file cost reports "on an annual basis with reporting periods based on the provider's accounting year." Another of the Secretary's cost reporting

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mediary's final reasonable cost determinations." The House Bill "provided for the establishment of a Provider Reimbursement Review Board which would review cases involving medicare providers of services." H.R. Conf. Rep. No. 1605, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 5370, 5387-88.

[5]As observed in *Chevron*, when Congress has "explicitly left a gap for the agency to fill" the Secretary has "an express delegation of authority . . . to elucidate a specific provision of the statute by regulation." *Chevron*, 467 U.S. at 843-44.

[6]Section 405.406(b) further declares that "[i]n the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultative assistance to providers." Thus, the Secretary lays down the policy of directing consultation between the provider and the intermediary in interpreting and applying "the principles of reimbursement." Such consultation about "reimbursement" matters would likely embrace notification by a provider to its intermediary of any request for reimbursement.

[7]Published in 31 Fed. Reg. 14810 (1966).

requirements, adopted on October 13, 1972, added a new subsection (f) to 42 C.F.R. § 405.453.[8] This subsection states in its introductory paragraph:

> (f) *Cost reports.* For cost reporting purposes, the health insurance program requires each provider of services to submit periodic reports of its operations which generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information which has been previously submitted by a provider may be permitted or required as determined by the Social Security Administration.[9]

The Secretary's regulations also detailed the required content of the provider's cost report. Since 1966 the Secretary had specified in 42 C.F.R. § 405.454(f)[10] that while interim payments could be made to a provider, "[a]ctual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified." Reasonably read, this regulation informed Congress and continues to inform pro-

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[8]37 Fed. Reg. 21630 (1972).

[9]Sec. 405.453(f) provides in paragraph 2:

> *Due dates for cost reports.* (i) Cost reports are due on or before the last day of the third month following the close of the period covered by the report . . . .

[10]This section states:

> *Retroactive adjustment.* (1) Title XVIII of the Act provides that providers of services shall be paid amounts determined to be due, but not less often than monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services rendered to program beneficiaries during that period.

viders that to secure reimbursement for its "actual costs" a provider must list in the cost report each cost for which reimbursement is requested and must furnish sufficient information in the cost report to enable the fiscal intermediary to verify each reimbursement request.

With knowledge of the cost report filing requirements in the Secretary's regulations, Congress in section 1395oo(a)(1)(A)(i) specified a further condition which a provider of services must meet. A provider may only obtain a Board hearing "if" it is "*dissatisfied* with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . ." (emphasis added).[11] Reasonably read, this provision requires as a condition precedent for a provider obtaining a Board hearing that the provider show that it is "dissatisfied with a final determination" of the intermediary. To show dissatisfaction a provider must evidence dissatisfaction with respect to one or more items of that final determination for which the provider believes that it incorrectly received only partial reimbursement or no reimbursement at all. It follows that there must be a recorded predicate in the provider's cost report for any such dissatisfaction. It is therefore concluded that the foregoing provision of section 1395oo(a) requires that, to show dissatisfaction, the provider must have first made a claim in its cost report for reimbursement as to the item for which it was denied reimbursement in whole or in part.

The foregoing analysis of Section 1395oo(a) and the Secretary's relevant regulations support the Board's statement[12]

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[11]Inapplicable are sections 1395oo(a)(1)(A)(ii) ("dissatisf[action] with a final determination of Secretary"); (1)(B) (failure of a provider to receive a final determination from an intermediary "on a timely basis after filing such report"), and (1)(C) (failure of a provider to receive a final determination on a timely basis after filing a supplementary cost report).

[12]The Board's "supplemental explanation for denial of jurisdiction" thus speaks to the Secretary's regulations:

that the requirements to secure a Board hearing set forth in Section 139500(a) are "jurisdictional." Moreover, this construction of section 1395oo(a) is not "inconsistent with the statutory mandate."

C.

In *Saline Community Hospital Association* v. *Secretary*, 744 F.2d 517, 519 (6th Cir. 1984), this court noted that "[t]he requirements for administrative review by the Board are contained in 42 U.S.C. § 1395oo(a)." In upholding the Provider Reimbursement Review Board's "determination that it lacked jurisdiction," this court ruled:

> The claims at issue were *not* initially included in the cost reports, and they were not properly tendered as "amendments" to the cost reports.

Id. at 520 (emphasis in original).

The determination in *Saline* that section 1395oo(a) sets forth jurisdictional requirements for Board review of an intermediary's decision is consistent with the conclusion reached above in the instant case. However, since other

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The regulations provide that, as a condition precedent, the provider must have claimed the cost in its filed cost report to give rise to any controversy. The Provider may also preserve appeal rights by filing a clear overt disclosure of its disagreement for a particular disputed item(s) which may relate to such matters as certain self-disallowed or unclaimed costs. When the provider files a cost report, it must either claim the particular cost or state its claim and disclose its position on an issue so the intermediary can consider and make a final determination. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. The Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report and the disputes arising from costs claimed and/or any clear disclosure of a particular disputed item with the filed cost report.

courts have determined that section 1395oo(d), rather than section 1395oo(a), controls the jurisdiction of the Provider Reimbursement Review Board, it is essential now to analyze this related section entitled "Decisions of Board."

The first sentence in Section 1395oo(d)[13] provides that the decision shall be "based upon the record made at such hearing, which shall include evidence considered by the intermediary and such other evidence as may be obtained or received by the Board." This language explicitly allows the Board to augment the appellate evidentiary record, giving a *de novo* attribute to the hearing.[14] Thus, this sentence indicates that a provider is entitled to a hearing in which it can retry issues raised before the fiscal intermediary. But the sentence does not state or imply that the provider can obtain a new trial of an issue not raised before the fiscal intermediary.

The second and final sentence of the section defines the Board's powers in rendering its decisions.[15] The term "power," in this context, is understood to be used interchangably with the term "jurisdiction." The elusive term "jurisdiction" has been defined as follows:

> In the general sense [jurisdiction] signifies the abstract right of a tribunal to exercise its powers in causes of a certain class, and in the particular sense

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[13]Section 1395oo(c), not here applicable, guarantees a provider's right to counsel at the hearing, "to introduce evidence, and to examine and cross-examine witnesses." Evidence may be received even though inadmissible under "rules of evidence applicable to court procedure."

[14]The first sentence concludes with a requirement that the decision of the Board "shall be supported by substantial evidence when the record is viewed as a whole."

[15]The Board "shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination."

> it relates to the right of a tribunal to exercise its power with respect to a particular matter.[16]

Hence, the final sentence of section 1395oo(d) may be read as providing the Board two separate sources of power or jurisdiction. First, "with respect to a [provider's] cost report" the Board is granted the "power to affirm, modify, or reverse a final determination of the fiscal intermediary." This grants a range of authority that is traditionally available to an appellate tribunal. As a second grant of power or jurisdiction the Board may "make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." Thus the Board is given power to make a revision on a matter "covered by such cost report" that is either "adverse to the provider of services," or, impliedly, that is beneficial to the provider. Plainly, the Board is given authority not included in the first grant of power. The extent of this supplemental power or jurisdiction to "make any other revisions" needs further analysis.

As observed earlier, the fiscal intermediary cannot appeal its final determination to the Provider Review Reimbursement Board. Nor does the statute authorize the Board *sua sponte* to certify for review a final determination of an intermediary. Hence, the Board may exercise its power to revise a final determination, granted by the final sentence of § 1395oo(d), only when a provider properly appeals to the Board from a final determination of an intermediary.

As seen, it has been determined, *supra* part I.B., that section 1395oo(a) requires a provider to make a claim to the fiscal intermediary for reimbursement with respect to a matter covered by the provider's cost report as a condition precedent for appealing to the Board the intermediary's final deter-

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[16]20 Am. Jur. 2d *Courts* § 87 (1965).

mination. Should the provider fail to make a claim for reimbursement to the fiscal intermediary the provider could not prosecute an appeal to the Board from the fiscal intermediary's final determination denying reimbursement of that claim.

Despite the provider's failure to make a claim for reimbursement, the question remains whether the Board nonetheless has jurisdiction to review the intermediary's final determination by virtue of the ending clause of section 1395oo(d) —"even though such matters were not considered by the intermediary in making such final determination." Preliminarily, it is noted that the word "considered" in this clause also appears in the first sentence of section 1395oo(d), which states that the record of the Board hearing includes "the evidence considered by the intermediary."

Using the primary definition of the transitive verb "to consider," we will construe the verb "considered" as used in section 1395oo(d) to mean "attentively inspected or examined."[17] Under this construction of "considered," an intermediary could not attentively inspect or examine a "matter covered in the cost report" for which the provider made no claim for reimbursement. Therefore, it is concluded that the ending clause of section 1395oo(d) could not and does not give the Board the power or jurisdiction *de novo* to take up such claim of the provider that was not claimed for reimbursement. However, under the ending clause the Board would have the power or jurisdiction to revise an intermediary's final determination, adversely or beneficially to the provider, as to a matter "covered by [the provider's] cost report" and claimed to be reimbursable, which claim the

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[17]Webster's New International Dictionary 568 (2d ed. 1942) defines "consider" in its primary definition as "[t]o look attentively; to inspect; examine."

intermediary had an opportunity to attentively inspect or examine, but did not.[18]

Applying the foregoing interpretations of sections 1395oo(a) and (d) and the Secretary's relevant regulations, this court concludes that the Board properly denied the Hospital's appeal. The failure of the Hospital to expressly and timely claim reimbursement for "the costs of interns' and residents' education and all related overhead in connection with the Hospital's Family Practice Clinic and Central Psychiatric Clinic" denied jurisdiction to the Board to hear the Hospital's appeal. The Hospital's self-disallowance of these costs, without making claim for reimbursement of these costs, deprived the intermediary of an opportunity to "consider" the items even though the items were "matters covered by [the provider's] cost report."

II.

A.

The court now tests its interpretations of sections 1395oo(a) and 1395oo(d) by examining the most pertinent federal court decisions.[19] In *Athens Community Hospital, Inc.*

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[18]In *Saline, supra*, 744 F.2d at 519, this court similarly construed § 1395oo(d) to require a provider to "include disputed issues within the initial cost report and preserves the right of review if the intermediary *ignores the claim*, or instructs the provider to delete the claim" (emphasis added).

[19]After completing the text of this opinion, its author received and later read *Baptist Hospital East v. Secretary*, No. 85-5473 (6th Cir. Oct. 6, 1986). Affirming the district court, Judge Engel, (a member of the per curiam panel in *Saline, supra*) stated: "We do not believe that a mere self-disallowance even when made solely to conform to regulations with which a provider disagrees raises a claim within the meaning of *Saline* sufficient to preserve the issue for review by the Provider Reimbursement Review Board." Slip op. at 6. As seen above, this court similarly determined that a provider's self-disallowance of costs does not constitute a claim. In this respect, and in requiring a claim for

v. Schweiker, 743 F.2d 1 (D.C. Cir. 1984) (*Athens* II), the D.C. Circuit reheard and reaffirmed it's prior decision in *Athens* I, 686 Fed.2d 989 (D.C. Cir. 1982). While modifying its reasoning in certain respects, the court affirmed it's "previous determination that [Hospital Corporation of America] may not recover the income tax and stock option cost that it failed to claim." 743 F.2d at 10. With respect to the income tax cost, the court said "[a]t best, HCA's claim . . . can be characterized as a 'self-disallowance' " and "its claim with respect to the stock option cost is clearly not even that, for HCA contends only that it was 'directly related' to a category of cost and issue." The court then held:

> As such, the PRRB was correct in holding that it did not have jurisdiction to consider these costs because the intermediary was never given the opportunity to make a final determination about them. Any dissatisfaction on the part of HCA must be with its own failure to claim these costs in a timely fashion.

Id.

In an earlier part of the opinion, the *Athens* II court declared:

> The PRRB's jurisdiction, as defined by section 1395oo(d), must be read in light of the Board's functions as set out by section 1395oo(a).

Id. at 6. Continuing, the court explained:

> That section states that a provider "may obtain a hearing with respect to [a required] cost report" if

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reimbursement of costs to be made to the fiscal intermediary to preserve the issue for appeal to the Provider Reimbursement Review Board, this court's opinion is consistent with *Baptist Hospital East*. Moreover, as the concurring opinions point out, *Baptist Hospital* (i.e. part II) decides the same issue presented on this appeal and "[w]e are controlled by that decision."

> a provider "is dissatisfied with a final determination of the . . . fiscal intermediary."

Id. Referring to section 1395oo(a), the court then observed:

> The subject of the hearing is plainly the cost report and the cost report is the subject of the "final determination." It would be anomalous, moreover, to say that a provider can appeal only when "dissatisfied" while allowing the provider to obtain review of an intermediary's refusal to reimburse the provider for a cost it did not even claim. We do not think Congress intended to permit a provider to claim dissatisfaction based upon its own failure to request reimbursement of a cost item.[20]

Id. The *Athens* II court thus makes it evident that filing a claim with the fiscal intermediary is essential to a provider obtaining a Board hearing on such claim. This portion of the *Athens* II court's reasoning conforms to the conclusion reached herein in part I.B. *supra.*

In concluding that a provider must make a claim for reimbursement before obtaining review by the Board, the D.C. Circuit declined to adopt the Seventh Circuit's reading of section 1395oo(d) in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services,* 698 F.2d 1337 (7th Cir.), *cert. denied,* 464 U.S. 830 (1983). After quoting 42 U.S.C. § 1395oo(d), the Seventh Circuit held:

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[20]Continuing, the court stated:

> If a provider is unhappy with the reimbursement the intermediary allowed in such a case, it is the fault of the provider and not of the intermediary. It simply is not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for, even though it did not request them.

743 F.2d at 6.

> This section vests broad authority in the Provider Reimbursement Review Board to review the finding of the fiscal intermediary and make any adjustment to the cost reports the Board deems necessary. As the statute itself expressly states, the Board may consider any matter "even though such matters were not considered by the intermediary in making such final determination."

Id. at 1346. The court then declared:

> Therefore, since the statute allows the Board to consider matters outside of the cost reports, we hold the Provider Reimbursement Review Board had the authority to consider whether the costs of providing Medicare patients with bedside telephones are reimbursable expenses under the Medicare Act.[21]

Id.

In *Athens* II, the D.C. Circuit rejected the Seventh Circuit's reading of the statute, explaining that such reading ignores and would make meaningless that part of the statute expressly limiting the PRRB's power to 'affirm, modify, or reverse a final determination of a fiscal intermediary . . . and to make . . . revisions' to '*matters covered by* [*a*] *cost report.*' " 743 F.2d at 6 (emphasis in original). This court agrees with this reason for rejecting the Seventh Circuit's analysis. In addition, we believe the Seventh Circuit analysis is flawed due to its failure

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[21] *In Community Hosp. of Roanoke Valley v. Health and Human Serv.*, 770 F.2d 1257, 1262 (4th Cir. 1985), the Fourth Circuit rejected the reasoning of the Seventh Circuit and approved the reasoning of the D.C. Circuit. The court quoted language of *Athens* II that the Board's jurisdiction as defined by section 1395oo(d), must be read in light of the Board's functions as set out by section 1395oo(a). But finally the court agreed with the D.C. Circuit "that the scope of jurisdiction conferred by section 1395oo(d) is limited to matters 'put into dispute by the provider at the time the cost report is filed.' "

to read section 1395oo(d) in light of section 1395oo(a)'s jurisdictional requirements, as previously examined.[22]

Thus, this court finds the district court's reliance on *St. Mary of Nazareth Hospital Center*, rather than *Athens Community Hospital*, misplaced, and we must reject the district court's determination that *St. Mary of Nazareth Hospital Center* "announces the correct interpretation of the jurisdictional bounds contained in 42 U.S.C. § 1395oo(d)."

B.

In part III. of its opinion, the D.C. Circuit declared in *Athens* II that the "primary obstacle" in interpreting the statute is "how can 'matters' have been 'covered by [a] cost report' but not have been 'considered by the intermediary'?" 743 F.2d at 9. In the ensuing two sentences the D.C. Circuit does not retreat from its earlier conclusion and its final judgment that the provider must expressly request or claim a cost to the intermediary to make it reimbursable:

> Because the cost report by its very nature tells the intermediary which costs are claimed, implicit in an intermediary's every determination of a final reimbursement figure is consideration of everything the provider requested. The amount requested is either awarded or it is not, but a decision is made as to all that is expressly claimed.

Id. Concluding "that there is only one way of reading the statute that does give effect to both clauses of section 1395oo(d)," the D.C. Circuit then states:

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[22]In *United States v. Withrow*, 593 F.2d 802, 804 (7th Cir. 1979), the Seventh Circuit recognized, under 42 U.S.C. § 1395oo, that:

> If the provider is *dissatisfied* with the determination of the intermediary . . . the provider may obtain a hearing before a Provider Reimbursement Review Board. . . .

(Emphasis added.)

> That is to interpret the statute as allowing the PRRB to revise aspects of the reimbursement calculation not actually contested by the provider, and possibly not considered by the intermediary (because not claimed for reimbursement by the provider), when such revision is necessary to accommodate other PRRB revisions of matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB. The provider, however, is allowed to appeal only such adverse decisions of the intermediary. Because this is the only plausible reading of this section that does not have the effect of rendering one part or the other meaningless, we believe that it is proper for us to adopt it.

Id.

With deference to the D.C. Circuit's conclusion that there is "only one way of reading the statute that does give effect to both clauses of section 1395oo(d)," this court has reached a different conclusion. This court has construed the ending clause of that section to empower the Board to revise an intermediary's final determination, adversely or beneficially to the provider, as to a matter covered by the cost report and claimed to be reimbursable, which claim the intermediary had an opportunity to attentively inspect or examine, but did not.

C.

The Hospital heavily relies on *Bethesda Hospital v. Heckler*, No. C-1-83-622 (S.D. Ohio Apr. 30, 1985). In that case, Judge Spiegel granted summary judgment in favor of Bethesda and Deaconess Hospitals against the Secretary. As pertinent here, the district court ruled in the first part of its opinion that the Provider Reimbursement Review Board erred in concluding that it lacked jursidiction over the hospital's appeal to the Board because Bethesda and Deanconess

made no claim for reimbursement to the intermediary.[23] The court recognized that "the PRRB concluded that, under the statutory administrative review scheme, 42 U.S.C. § 1395oo(a)-(f), it lacked jurisdiction over their appeal from the final determination of the fiscal intermediary because Bethesda and Deanconess made no claim for reimbursement to the intermediary." Slip op. at 4. However, the court concluded that the "grant of authority to the PRRB to review determinations made by the fiscal intermediary contained in section 1395oo(d) is more appropriately limited to those items disclosed in the cost report such that all figures necessary to any calculations are contained in the cost report." Slip op. at 15. Therefore, "the PRRB erred in concluding that it had no jurisdiction to review Bethesda and Deaconess Hospitals' claims for reimbursement of self-disallowed costs." *Id.*

Applying to section 1395oo(d) the statutory rule of construction that words of a statute should be given their "ordinary and intended meaning," the court declared with reference to section 1395oo(d):

> [A] requirement of an overt claim for reimbursement to the fiscal intermediary as a condition precedent to PRRB review is implicit at best, and in apparent contradiction to the broad grant of authority to the PRRB to revise "matters covered by [the] cost report even though such matters were not considered by the intermediary in making such final determination."

Slip op. at 7. However, as this court's analysis of section 1395oo(a), *supra* part I.C. demonstrates, one must look at

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[23]Plaintiffs Bethesda and Deaconess did not file a claim with the fiscal intermediary for reimbursement for malpractice insurance costs. Instead, "Bethesda and Deaconess filed a cost report with the fiscal intermediary in compliance with the new Malpractice Rule, and hence 'self-disallowed' reimbursement for the additional portion of malpractice insurance costs allowable under the old rule." Slip op. at 4.

section 1395oo(a) as well as § 1395oo(d) to determine whether there is "a requirement of an overt claim for reimbursement to the fiscal intermediary as a condition precedent to PRRB review." As previously held, the pertinent language of section 1395oo(a) requires as a condition precedent for a provider to obtain a Board hearing that the provider show that it is "dissatisfied with a final determination" of the intermediary. Moreover, as previously concluded, the foregoing provision of section 1395oo(a) requires that, to show its dissatisfaction, the provider must have first made a claim or otherwise notified its intermediary as to the item for which it sought and was denied cost reimbursement.[24] We therefore decline to accept the reasoning in *Bethesda Hospital*.

III.

Attention is now turned to the remaining issue raised by the parties. In its motion for summary judgment before the district court, the Hospital stated:

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[24]The district court in *Bethesda* noted that under section 1395oo "the PRRB may conduct an administrative review of the intermediary's final decision," and then stated:

> Perhaps less obvious but nevertheless evident is the legislative intent that the PRRB review need not be limited to costs claimed by the provider to the intermediary in the cost report.

Slip op. at 6.

A search of the House and Conference Reports of the legislative history, highlighted *supra* part I.B., has revealed no expressed intent to allow the PRRB review of costs not claimed by a provider; and no such intent may be implied from the legislative history. To the contrary, as quoted earlier, the House Report shows that the committee believed it was "desirable to prescribe in law a specific procedure for settling *disputed* final determinations" (emphasis added). A final determination would only be "disputed" if the provider claimed a cost payment to be reimbursable and the fiscal intermediary, in its final determination, either disallowed the claim as not reimbursable or ignored the claim.

> [S]ubsequent to the filing of its third and final cost report . . . the Hospital learned of an important judicial decision which held that the Pennsylvania State University could obtain reimbursement for its costs incurred at similarly situated clinics on behalf of Medicare-eligible patients. See *The Pennsylvania State University v. Secretary, PRRB* Dec. No. 79-D89, CCH Medicare and Medicaid Guide, ¶ 30,379, *reversed and remanded* (D.C.M.D.Pa., 1981)., CCH Medicare and Medicaid Guide, ¶ 30,989, and 79-D89R, CCH Medicare and Medicaid Guide, ¶ 31,635.

On October 30, 1981, the Hospital filed its third and final cost report for fiscal years ending June 30, 1979, June 30, 1980 and June 30, 1981. The Secretary points out that the Notice of Program Reimbursement (NPR) was not issued in this case until September 30, 1982, and states that until this time "the provider clearly could have sought to have its cost report amended by the intermediary."[25]

It is recognized that a provider may seek to amend a cost report filed with the intermediary prior to the intermediary's issuance of a Notice of Program Reimbursement (NPR). *University of Michigan Hospitals v. Heckler*, 609 F.Supp. 756,

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[25]42 C.F.R. § 405.453(f) provides, in pertinent part:

> Amended cost reports to revise cost report information which has been previously submitted by a provider may be permitted or required as determined by the Health Care Financing Administration.

The Medicare Intermediary manual, HIM-13-2 § 2631.2A, states:

> A provider may file or an intermediary may require an amended cost report to:
>
> 1. correct material errors detected subsequent to the filing of the original cost report,
> 2. comply with the health insurance policies or regulations,
> 3. reflect the settlement of a contested liability.

761 (E.D. Mich. 1985). However, whether or not under HIM-13-2 § 2631.2A, *supra* note 25, the Hospital could have amended its self-disallowed clinic costs to request reimbursement need not be pursued. The failure of the provider to seek such amendment moots the point.

The intermediary issued its Notice of Program Reimbursement on September 30, 1982. By letter of March 30, 1983, the provider requested a Board hearing. This is the first time that it sought reimbursement for the interns' and residents' education costs.

As noted by the Secretary, the Medicare regulations and the Intermediary Manual make provision for reopening an intermediary's final determination. Thus 42 C.F.R. § 405.1885(a) provides, as here pertinent, "a determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination . . . by such intermediary . . . on motion of such intermediary . . . or on the motion of the provider affected by such determination . . . to revise any matter in issue at any such proceedings." The request must be made within three years of the date of the notice of the intermediary. The Medicare Intermediary Manual, HIM-13-2 § 2631, thus defines "reopening":

> For the purposes of this section the term "reopening" means an affirmative action taken by an intermediary . . . to re-examine or question the correctness of a determination or decision otherwise final. . . .
>
> For example, under the provisions of this paragraph an amended cost report accepted by an intermediary after its issuance of the initial determination of the amount of program reimbursement would be deemed to constitute a request by the provider to reopen an intermediary's determination.

Section 2631.2 of the Intermediary Manual specifies these circumstances under which a determination may be reopened:

> *2631.2 Reopening Final Determination on Cost Reports*
>
> Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.[26]

The Secretary argues that under the "reopening" provisions "the provider clearly had an opportunity to seek to claim these costs after the issuance of the NPR but had failed to do so." To the contrary, the Hospital asserts that its "situation did not entitle it to reopen or amend its cost reports, 42 C.F.R. §§ 405.453(f), 405.1885, and thus neither of those routes were pursued." The Hospital adds:

> Had the Hospital attempted to pursue a reopening or an amendment, it would have had no remedy to the Intermediary's denial of such request since such decisions are final and non-appealable.

The Hospital refers to C.F.R. § 405.1885(c), which states:

> Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

University of Michigan v. Heckler, supra, 609 F.Supp. at 762, rejected a claim of the group of hospitals that "fiscal intermediaries should not possess complete discretion over hospitals' requests to reopen."[27]

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[26]The regulation continues:

> Information submitted in support of an amended cost report or the audit findings on a previously unaudited cost report (§ 2004) could provide new and material evidence on which to base a reopening.

[27]Judge Joiner reasoned:

Because the University of Cincinnati Hospital did not seek to reopen the NPR after the intermediary issued the NPR on September 30, 1982, the question of reopening is not raised in this case. Therefore, this question is not properly before this court and will not be resolved.

IV.

Having concluded that the district court committed prejudicial error as explained and specified in parts I and II, the district court's ruling is reversed. The case is remanded to the district court to enter an order granting the Secretary's motion for summary judgment.

> The reopening procedures of the Medicare regulations reflect the judgment that the providers' ability to add claims to cost reports must end at some point. The issuance of the NPR was selected as that point. Accordingly, the regulations give the fiscal intermediary complete discretion over requests to alter cost reports that are made after the issuance of the NPR.

Id. at 762-63.

MERRITT, Circuit Judge, concurring. Since this case was argued and submitted on April 25, 1985, Judge Engel on October 6, 1986, in his unanimous opinion for the Court has decided the issue under submission here.

Baptist Hospital East v. Secretary, No. 85-5473, decides precisely the same issue presented on this appeal. We are controlled by that decision. For that reason, I concur in the result reached in the opinion circulated by Judge Thomas.

JONES, Circuit Judge, concurring. This Court's decision in *Baptist Hospital East v. Secretary*, No. 85-5473, addressed the issue before us on this appeal. Because we are controlled by that decision, I concur in the result of Judge Thomas' opinion.

No.85-3651

IN THE

United States Court of Appeals
for the Sixth Circuit

UNIVERSITY OF CINCINNATI, d/b/a UNIVERSITY HOSPITAL *Plaintiff-Appellee*	)
v.	) ORDER
SECRETARY OF HEALTH & HUMAN SERVICES *Defendant-Appellant*	)

BEFORE: MERRITT and JONES, Circuit Judges and THOMAS,* Senior United States District Judge

The Court having received a petition for rehearing *en banc*, and the petition having been circulated not only to the original panel members but also to all other active judges of this Court, and no judge of this Court having requested a vote on the suggestion for rehearing *en banc*, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

John P. Hehman, Clerk

*Hon. William K. Thomas sitting by designation from the Northern District of Ohio.